

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

070
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FILED FEB 18 1954

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **500** Registrar's No. **231**

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY St Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY 2079	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis	
c. LENGTH OF STAY (in this place) 5wks		d. STREET ADDRESS (If rural, give location) 5441 Thrush Av	
d. FULL NAME OF HOSPITAL OR INSTITUTION Halls Ferry Memorial Home			

3. NAME OF DECEASED (Type or Print)	a. (First) John	b. (Middle) Paul	c. (Last) Perhat	4. DATE OF DEATH (Month) (Day) (Year) Jan 23 1954
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH About 1882	9. AGE (In years last birthday) Abt 72	IF UNDER 1 YEAR Months	IF UNDER 2 WKS. Days	IF UNDER 24 HRS. Hours	IF UNDER 1 MIN. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Retired (wks)		11. BIRTHPLACE (State or foreign country) Jugoslavia		12. CITIZEN OF WHAT COUNTRY USA		

13a. FATHER'S NAME John Perhat	13b. MOTHER'S MAIDEN NAME Helen Brncich	14. NAME OF HUSBAND OR WIFE Petra
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. Wks.	17. INFORMANT'S SIGNATURE AND ADDRESS Petra Perhat 5441 Thrush Av
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic Carcinoma to lungs		
	ANTECEDENT CAUSES Skull etc.		
DUE TO (b) Primary unknown		unknown	
DUE TO (c) arteriosclerotic Cardiovascular disease		unknown	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **Jan 12, 1954**, to **Jan 23, 1954**, that I last saw the deceased alive on **Jan 19, 1954**, and that death occurred at **3:15 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Lewis Lillmann M.D.	23b. ADDRESS 8231 Clayton Rd (17)	23c. DATE SIGNED 1/25/54
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24a. BURIAL, CREMATION, REMOVAL (Specify) REBURIAL	24b. DATE 1/26/54	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St Louis Missouri
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DATE REC'D BY LOCAL REG. 1/25/54	REGISTRAR'S SIGNATURE Herbert R. ... M.D.	25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Moynell Funeral Home 1926 Allen Av
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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed Kenneth W. Robinson

Licensed Embalmer No. 9395

P. O. Address St. Louis 4

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

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